

Items 18&22a Film 414 MARYLAND STATE DEPARTMENT OF HEALTH
6-26-69 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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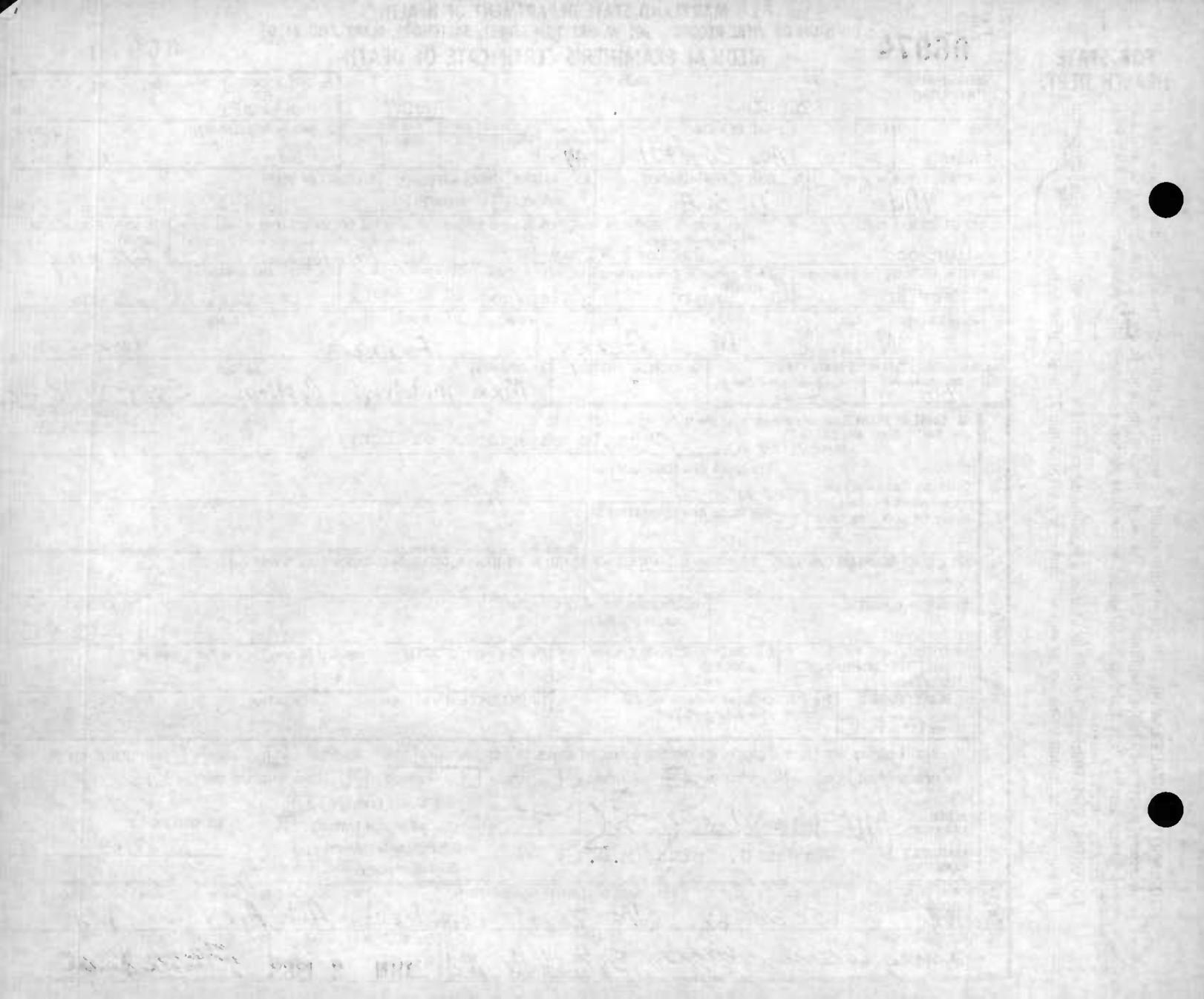
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)	First STERLING	Middle D.	Lost BERRY	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 19	Day M	Year	2b. HOUR	
3. SEX male	4. RACE negro	S. DATE OF BIRTH Aug. 30 1921	6. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR MONTHS 49	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month May	2d. HOUR Year 1969 p. m.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Howard						
10. CITY OR TOWN OF DEATH Glenwood	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Cattail River Farm			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) FARMER			12b. KIND OF BUSINESS OR INDUSTRY Evening		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Glenwood	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Cat Tail River Farm					
14. FATHER'S NAME Werner	First M.	Middle Berry	Lost	15. MOTHER'S MAIDEN NAME Francis	First	Middle	Lost		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	16c. INFORMANT ?	17. INFORMANT Mrs. Mildred Costley	ADDRESS Sykesville, Md.					
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Chronic emphysema of lungs									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause (b) _____									
DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?				
					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Werner Spitz</i> M.D.									
EXAMINER'S NAME (Type) Werner U. Spitz, M.D.									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
ADDRESS (Street, city, town, or county) 5/27/69									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-30-69	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		23d. LOCATION (City or Town) Mt. Airy	(County) Md.	(State)		
24. FUNERAL DIRECTOR Harry Wm Haight		ADDRESS Sykesville, Md.	25a. REGD BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE Oleander Judge				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Edith</i>	Middle <i>Damm</i>	Last <i>Damm</i>	2a. DATE OF DEATH Month <i>May</i>	2b. HOUR Day <i>16</i> Year <i>1969</i>				
3. SEX <i>female</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>Sept. 16, 1886</i>		6. AGE (In years lost birthday) <i>82</i>	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	HOURS <i>0</i>	MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Howard</i>						
10. CITY OR TOWN OF DEATH <i>Ellicott City</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harmon Rest Home</i>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>	13b. COUNTY <i>Howard</i>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <i>6220 Waterloo Road</i>						
14. FATHER'S NAME First <i>Elias Smallwood</i>	Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Maryarryman</i>	Middle <i></i>	Last <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>214-12-7710</i>	17. INFORMANT <i>Mrs. Grace Pfieffer, Waterloo Road, E.C. Md</i>	Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Upper Respiratory Tract Infection 1 week</i> 4134 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerotic Cardiovascular Disease ?</i> (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>April 16, 1967</i> , to <i>May 16, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 16, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Rolando V. Goco, M.D.</i>		DEGREE <i>M.D.</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5-17-69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Rolando V. Goco, M.D.</i>		22e. ADDRESS <i>608 Washington Blvd. Laurel</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>5-19-1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Trinity Chapel</i>	23d. LOCATION (City or Town) <i>Pfieffers Corner, Md</i>	(County) <i></i>		(State) <i></i>		
24. FUNERAL DIRECTOR <i>Higinbotham-Slack Funeral Home, Ellicott City, Md</i>				25a. REC'D BY REGISTRAR <i>MAY 20 1969</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06972

1. DECEASED-NAME (Type or print)		First DORIS	Middle V.	Lost	20. DATE OF DEATH Month May , Doy 14, 1969	2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH June 26 1914	6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard		
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 716 Northfield Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY	Md.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Howard		13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 715 Northfield Rd. 21043	
14. FATHER'S NAME First Harry Hammel		Middle	Lost	15. MOTHER'S MAIDEN NAME First Mary V. Cowman	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 213-36-4275		17. INFORMANT John F. Falter 715 Northfield Rd. 21043	Address Ellicott City		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno carcinoma of colon with generalized metastasis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 1538 (b) DUE TO, OR AS A CONSEQUENCE OF (c) approx 2 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) X							
19a. DATE OF OPERATION March 67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED carcinoma of bowel		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year no P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) no injury				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from March 1967 , to March 1969 , that (I) (we) last saw the deceased alive on 3/29/69 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE H. J. Welch, M. D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/15/69	
22d. PHYSICIAN'S NAME (Type) Dr. Hugh J. Welch		22e. ADDRESS 1205 N. Calvert Street, Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE May 17, 1969	23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County) Maryland	(State) Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229		25a. REC'D BY REGISTRAR MAY 16 1969	25b. REGISTRAR'S SIGNATURE Charles Judge		

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

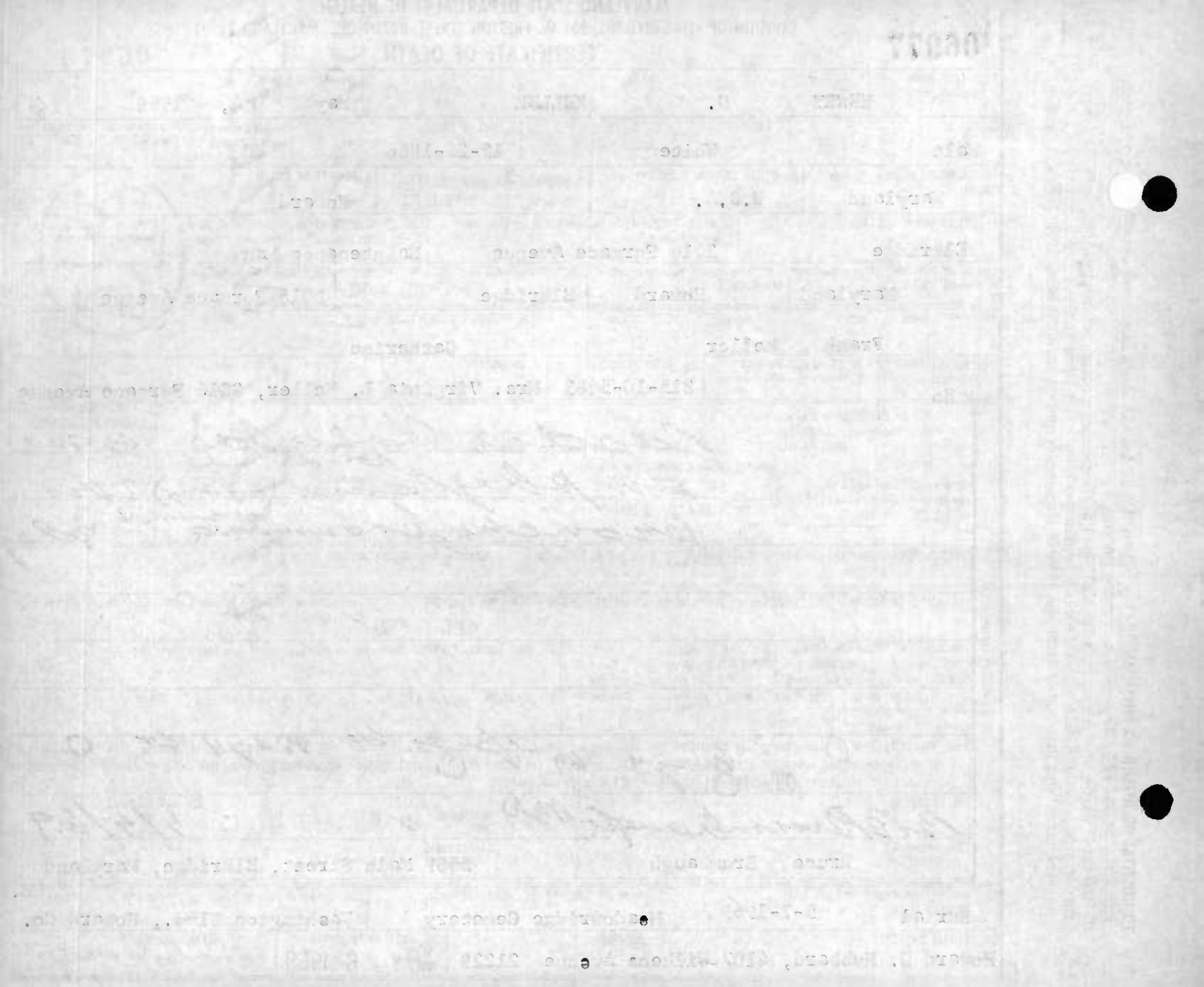
CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First HENRY	Middle G.	Last KELLER	2a. DATE OF DEATH Month May	Day 4, 1969	2b. HOUR 12:00 P.M.			
3. SEX Male		4. RACE White		S. DATE OF BIRTH 12-26-1888	6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	2b. HOUR HOURS	2b. HOUR MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard					
10. CITY OR TOWN OF DEATH Elkridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2016 Furnace Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance Man		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Howard		13c. CITY OR TOWN Elkridge	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2016 Furnace Avenue				
14. FATHER'S NAME First Frank		Middle Keller	Last	15. MOTHER'S MAIDEN NAME First Catherine						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 215-10-5483		17. INFORMANT Mrs. Virginia L. Keller, 2016 Furnace Avenue		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		<i>Cardiac Vascular Disease Emphysema (Bronchial) Bronchopneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.	Month May Day 4 Year 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. 5609 Main Street, Elkridge, Maryland	City or Town Elkridge		County Howard Co.	State Md.		
22a. I certify that (1) (this hospital) attended the deceased from April 25, 1969 , to May 4, 1969 , that (1) (we) last saw the deceased alive on May 4, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Bruce Brumbaugh MD</i>		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 5/5/69				
22d. PHYSICIAN'S NAME (Type) Bruce Brumbaugh		22e. ADDRESS 5609 Main Street, Elkridge, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-7-1969	23c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Cemetery		23d. LOCATION (City or Town) Washington Blvd., Howard Co.		(County) Howard Co.		(State) Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		ADDRESS 21229	25a. REC'D BY REGISTRAR MAY 6, 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

06978

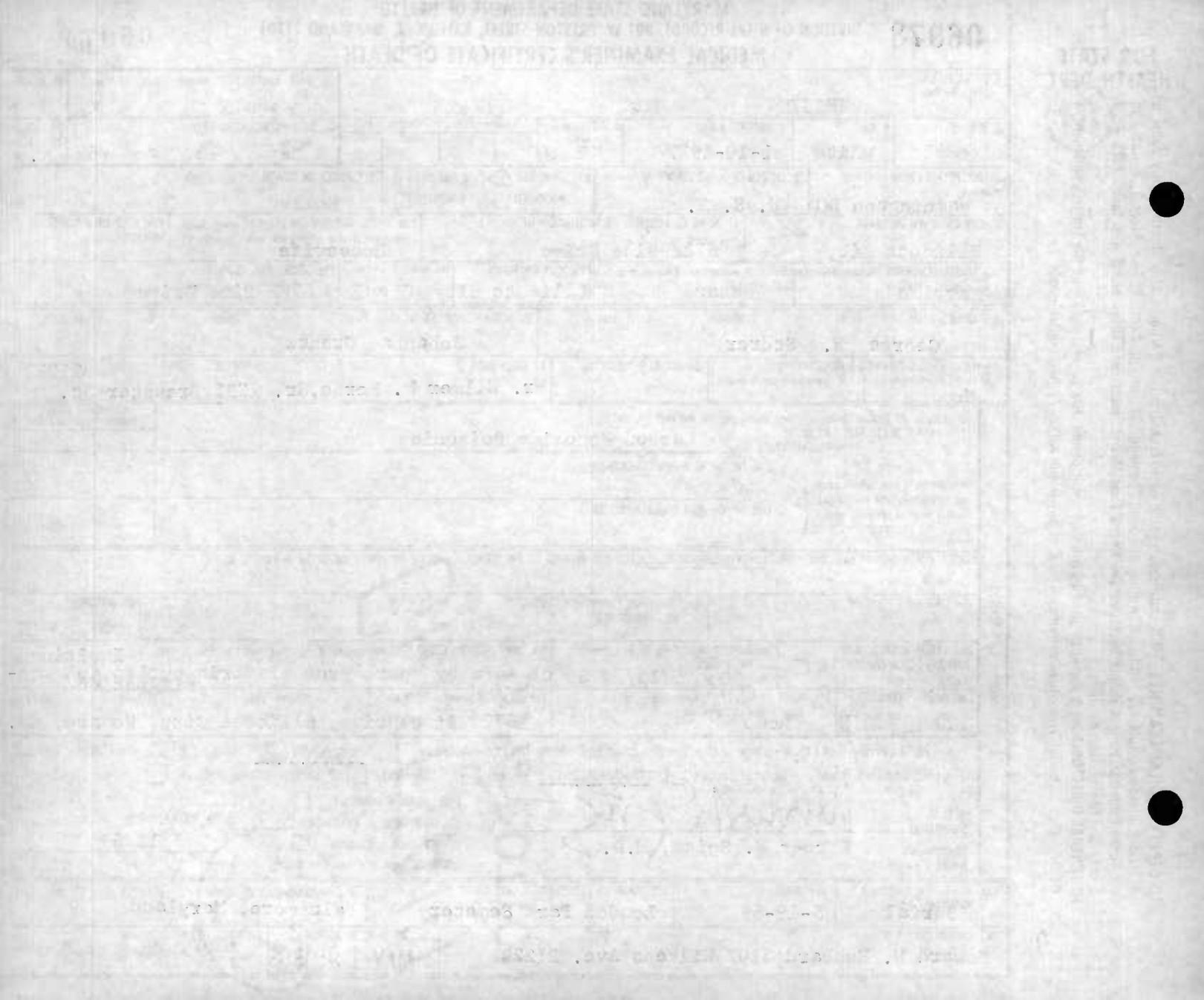
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06974

1. DECEASED NAME (Type or Print)		First BESSIE	Middle MAE	Last KERBE	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month 19	Day M	Year 1969	2b. HOUR 9:35 A.M.			
3. SEX female	4. RACE white	5. DATE OF BIRTH 1-10-1927		6. AGE (in years last birthday) 42 yrs.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month May	Day 13	Year 1969	2d. HOUR 9:35 A.M.
7a. BIRTHPLACE (State or foreign country) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard				
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6722 Pine Drive				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife				12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before commission STATE Maryland)		13b. CITY OR TOWN Howard		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER 6722 Pine Drive						
14. FATHER'S NAME George W. Storer		First	Middle	Last	15. MOTHER'S MAIDEN NAME Johanna Grentz		First	Middle	Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. Wilmer M. Kerbe, Sr.		ADDRESS 1232 Brewster St.				21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Carbon Monoxide Poisoning										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
890 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION MEDICAL CERTIFICATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 4:30 P.M. 5/13/1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Ignition of sofa by spark from electric outlet and con- flagration								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town 6722 Pine Drive, Ellicott City, Howard, Md.								
22o. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Werner U. Spitz, M.D.</i>		M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>												
ADDRESS (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-19-69		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d. LOCATION (City or Town) Baltimore, Maryland		(County)	(State)			
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229				25a. REC'D BY REGISTRAR DATE MAY 19 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

06979

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06975

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary; please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First MATTHEW	Middle JOHN	Last KERBE	2a. DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/>	Month 19	Day M	Year 1969	2b. HOUR 2d. HOUR 9:35 A.M.			
3. SEX male	4. RACE white	S. DATE OF BIRTH Nov. 24, 1964	6. AGE (in years lost birthday) 4 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month May	Day 13	Year 1969	2d. HOUR 9:35 A.M.
7a. BIRTHPLACE (State or foreign country) Florida	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard								
10. CITY OR TOWN OF DEATH Ellicott City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 6722 Pine Drive	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) 12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. CITY OR TOWN Howard	13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 6722 Pine Drive								
14. FATHER'S NAME Wilmer M. Kerbe	15. MOTHER'S MAIDEN NAME Bessie M. Storer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None	17. INFORMANT Wilmer M. Kerbe, Sr. 1232 Brewster St. 21227	ADDRESS								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carbon Monoxide Poisoning				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
890 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 4:30 PM 5/13 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Ignition of sofa by spark from electric outlet and conflagration							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home		21f. LOCATION Street or R.F.D. No. City or Town County State 6722 Pine Drive, Ellicott City, Howard, Md.							
22o. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED 5/13/69					
EXAMINER'S NAME (Type)		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, city, town, or county)							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 5-19-59		23c. NAME OF CEMETERY OR Crematory Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave. 21229				ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 19 1969	25b. REGISTRAR'S SIGNATURE Charles Judge				

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1972 EDITION
1972 EDITION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06976

06980

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR 8:50 P.M.		
James Vernon King							May	30	69			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday) 81 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male		White		Dec. 14, 1887								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Howard					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Airy		Route 2					Trackman-B&O R.R.					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER				
Howard Maryland		Howard		Mt. Airy				Route 2				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
		James		King				Margaret		Toms		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address					
No		705-12-2987		Mrs. Nellie A. King			Same As #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HyperTensive + Arterio sclerotic cardio-vascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>More than 10 years</u> 4122 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 22</u> , 19 <u>63</u> , to <u>May 28</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>May 28</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		<u>William B Culwell</u>			DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED. DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (Type)		<u>William B Culwell</u>			22e. ADDRESS			<u>900 South main St., Mt. Airy, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)		
Burial		6/2/1969		Poplar Springs			Poplar Springs		Howard	Md.		
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
C. M. Waltz, Box 241, Sykesville, Md.								JUN 3 1969				

Ocean

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

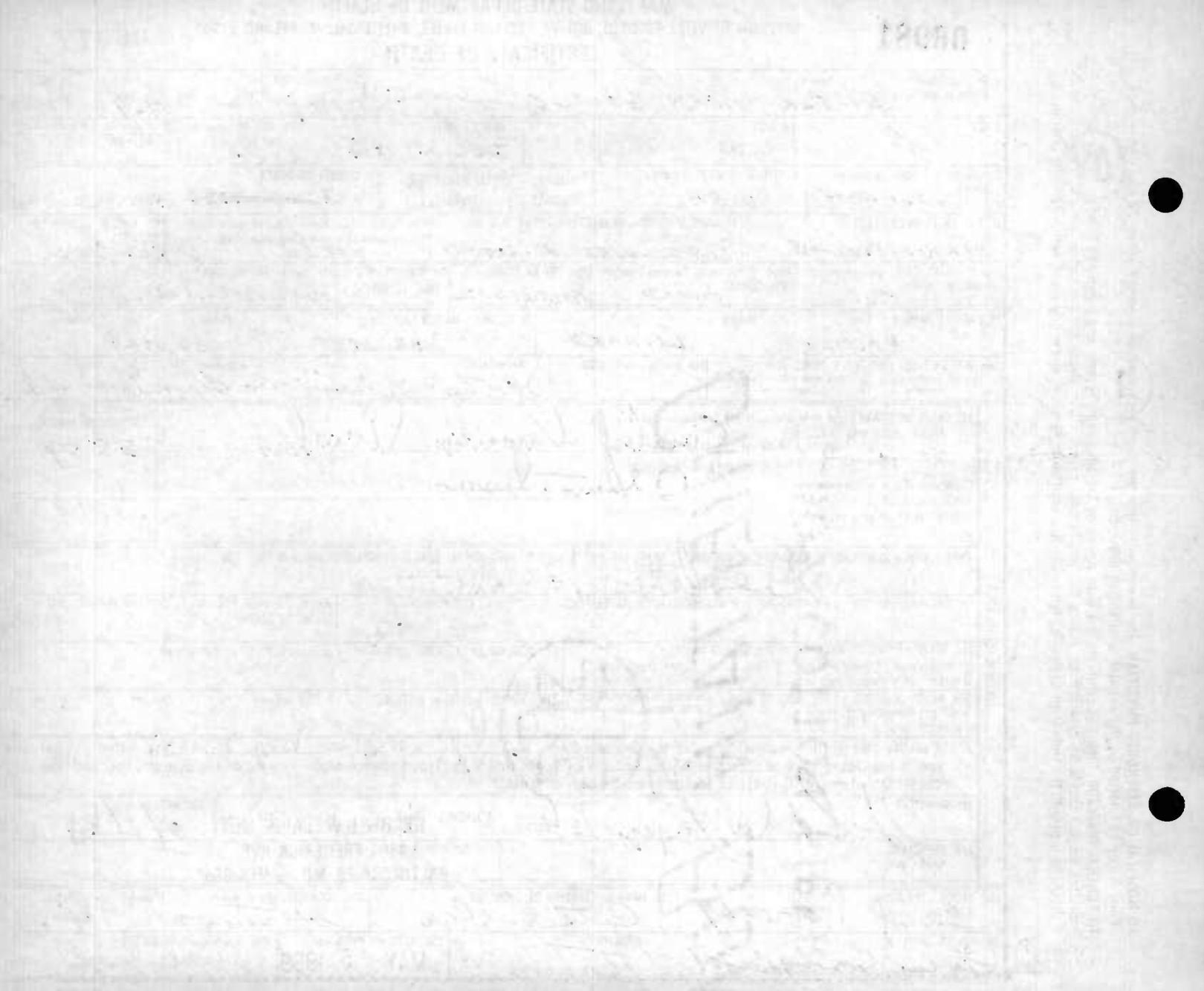
06977

CERTIFICATE OF DEATH

1	06981			20. DATE OF DEATH MAY Month, 2 Day Year 1969				2b. HOUR 8:15AM
1. DECEASED NAME (Type or print)		First <i>SISTER MARY GEORGE (LEONARD)</i>	Middle <i></i>	Lost <i></i>	20. DATE OF DEATH MAY Month, 2 Day Year 1969		2b. HOUR 8:15AM	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>DEC. 15, 1888</i>		6. AGE (In years lost birthday) <i>80</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>DELAWARE</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>BALTIMORE HANOVER</i>		
10. CITY OR TOWN OF DEATH <i>MARRIOTTSVILLE</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>BON SECOURS INFIRMARY</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>NURSE</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>RELIGIOUS</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD.</i>		13c. CITY OR TOWN <i>MARRIOTTSVILLE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>MARRIOTTSVILLE RD.</i>		
14. FATHER'S NAME First <i>PATRICK</i>		Middle <i>LEONARD</i>	Lost <i></i>	15. MOTHER'S MAIDEN NAME First <i>MARGARET</i>		Middle <i>CONOLE</i>	Lost <i></i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i>		16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Mother - Labours - Bon Secours Provincial Home</i>		Address <i></i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4369</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>Alcoholism</i>								
(b) DUE TO, OR AS A CONSEQUENCE OF <i></i>								
(c) <i></i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Deleter Bellaluz</i>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>May</i> Day <i>26</i> Year P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>	County <i></i>	State <i></i>
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>66</i> to <i>May 2, 1969</i> , that (I) (we) last saw the deceased alive on <i>May 2, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John N. Jones Jr.</i>		22c. DEGREE <i>ATTENDING PHYS.</i>		22d. ADDRESS <i>4804 FREDERICK AVE.</i>		22e. DATE SIGNED <i>5/31/69</i>		
22d. PHYSICIAN'S NAME (Type) <i></i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>		23b. DATE <i>5-5-69</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Cathedral Cem.</i>		23d. LOCATION (City or Town) <i>Baltimore</i>		(County) <i>Ind.</i>
24. FUNERAL DIRECTOR <i>Farley Corrington Jr. - Catonville Md.</i>		ADDRESS <i></i>		25a. REC'D BY REGISTRAR DAY <i>MAY</i> 5 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

06978

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First PAUL	Middle MARTIN	Last LUCAS	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 5	Day 30	Year 1969	2b. HOUR 1 p.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH 12-25-1913	6. AGE (In years last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month May	2d. HOUR 1 p.m.
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH Howard	
10. CITY OR TOWN OF DEATH Laurel		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Laurel Filtration Plant		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lanscaper				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington D.C.		13c. CITY OR TOWN Washington D.C.		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 1760 Lanier Place, Wash.			
14. FATHER'S NAME First Journey		Middle Lucas	Last	15. MOTHER'S MAIDEN NAME First Bertie		Middle Strole	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 218-03-3296		17. INFORMANT Kyger Funeral Home		ADDRESS Shenandoah, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty liver DUE TO, OR AS A CONSEQUENCE OF 5718 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardiovascular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						2d. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Edward F. Wilson</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED May 31, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6-1-1969		23c. NAME OF CEMETERY OR CREMATORIAL Lucas Family Cemetery		23d. LOCATION (City or Town) Shenandoah, Virginia		(County) (State)	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229		25a. REC'D BY REGISTRAR DATE JUN 2 1969		25b. REGISTRAR'S SIGNATURE <i>Howard Hubbard</i>			

STORY OF THE
WORLD WAR

THE STORY OF THE WORLD WAR

CHAPTER FORTY-TWO

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06983

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06979

1. DECEASED-NAME (Type or Print)		First EUGENE	Middle W.	Lost MOBLEY	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 5	Day 3	Year 1969	2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 2-11-1943	6. AGE (In years last birthday) 26 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month May Day 3 Year 1969			2d. HOUR 4:40 A.M.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard						
10. CITY OR TOWN OF DEATH Dorsey		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 32 at Dorsey Run Rd.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Dock Loader			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 1711 Levering Ave.					
14. FATHER'S NAME John E.B. Mobley, Sr.		15. MOTHER'S MAIDEN NAME Catherine D. Wrightson									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1964 - 1966		17. INFORMANT Mr. John E.B. Mobley, Sr.	17. ADDRESS 1711 Levering Ave.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrocranial injuries										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
8189 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 5-3 19 69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.) Apparently fell from cab of truck as it made left turn							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Highway		21f. LOCATION Street or R.F.D. No. Route 32 at Dorsey Run Rd.						City or Town Howard Md.	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.	
ACTUAL SIGNATURE <i>Charles S. Springate</i> EXAMINER'S NAME (Type) Charles S. Springate, M.D.										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-7-1969		23c. NAME OF CEMETERY OR CREMATORIAL Parkwood Cemetery			23d. LOCATION (City or Town) Baltimore, Maryland			(County) Maryland	(State)
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		ADDRESS 21229			25a. REC'D BY REGISTRAR DATE MAY 6 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

3. $\tau = 1$ $\tau = 2$ $\tau = 3$ $\tau = 4$ $\tau = 5$ $\tau = 6$ $\tau = 7$ $\tau = 8$ $\tau = 9$ $\tau = 10$

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06984

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06980

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Christian	Middle Neumann	Last	2a. DATE OF DEATH	Month May	Day 16	Year 1969	2b. HOUR	
3. SEX		4. RACE		S. DATE OF BIRTH	6. AGE (In years last birthday)				IF UNDER 1 YEAR	
Male		White		March 14, 1915	54	YRS.	MONTHS	DAYS	IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH					
Annapolis Md.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Howard					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Ellicott City		9218 Springvalley Rd.			Clergyman					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN COUNTY		13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
Maryland		Howard		Ellicot City	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	9218 Springvalley Rd.				
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last		
late George Neumann					late Amanda Dameyer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
(If yes, year or dates of service) WW II		219 18 1981		Mrs Christian Neumann		9218 Springvalley Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		4109 coronary occlusion								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause		due to, or as a consequence of Claudio Vasquez disease is a U. Block								
(b)		due to, or as a consequence of								
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION	Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 12/25, 1967, to 1/16, 1968, that (I) (we) last saw the deceased alive on 1/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		E. W. Johnson		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)		E. W. Johnson		ADDRESS	3432 8218	Frederick Ave.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)		(County)	(State)	
Burial		May 20, 1969		Zion Evangelical Lutheran		Golden King Rd.		Balto.	Co.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Howard County Funeral Home of Harry H. Witzke		Ellicott City Maryland								
30M REV. 1/68		DATE MAY 21 1969		Charles Judge						

58020

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06981

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06985

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First William	Middle F.	Last Stiegler	2a. DATE OF DEATH Month May 5 Day Year 13 69	2b. HOUR 3P M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9-20-1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard	
10. CITY OR TOWN OF DEATH Ellieott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Howard Co. Medical Center			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Plumber & Heating		
13a. USUAL RESIDENCE (Where deceased lived) if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Star Route # 1	
14. FATHER'S NAME Christian Stiegler		15. MOTHER'S MAIDEN NAME Marie Rapp			12b. KIND OF BUSINESS OR INDUSTRY Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-07-1257		17. INFORMANT Mrs. Elizabeth Stiegler, Star Rt. # 1 21784 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		acute myocardial infarction 301 DUE TO, OR AS A CONSEQUENCE OF Cerebrovascular C.V. Disease 10 yr.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1969</u> to <u>May 13, 1969</u> , that (I) (we) last saw the deceased alive on <u>May 13, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Christian S. Mass		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 5/13/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Balto. Nat'l. Pike & St. Johns Lane					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 5-17-1969		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery		23d. LOCATION (City or Town) Woodlawn, Maryland (County) (State)	
24. FUNERAL DIRECTOR Howard H. Hubbard		4107 ADDRESS Wilkins Ave.		25a. RECD BY REGISTRAR DATE MAY 15 1969		25b. REGISTRAR'S SIGNATURE Howard H. Hubbard	
Baltimore, Maryland 21229							

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20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print)			First <i>Eileen</i>	Middle <i>R.</i>	Last <i>Truitt</i>	2a. DATE OF DEATH Month <i>May</i>	Day <i>23</i>	Year <i>1969</i>	2b. HOUR <i>5 15 AM</i>				
3. SEX <i>9</i>		4. RACE <i>W</i>	5. DATE OF BIRTH <i>Feb. 15, 1917</i>			6. AGE (In years last birthday) <i>52</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Howard</i>							
10. CITY OR TOWN OF DEATH <i>Ellicott City</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>4918 Eastwood Place</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Clerk</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Howard</i>	13c. CITY OR TOWN <i>Ellicott City</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>4918 Eastwood Place</i>					
14. FATHER'S NAME First <i>Harry</i>		Middle <i>A. Smoot</i>	Lost	15. MOTHER'S MAIDEN NAME First <i>Mary</i>			Middle <i>A.</i>	Last <i>Kilroy</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-01-5926</i>			17. INFORMANT <i>C. Paul Truitt 4918 Eastwood Place</i>			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> .													
4124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Congestive Heart Failure</i>											6 M.		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterosclerotic Cardiovascular Disease</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arterosclerotic Cardiovascular Disease</i>											2 yrs.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from <i>8-23</i> , 19 <i>61</i> , to <i>5-23</i> , 19 <i>69</i> , that (I) (we) lost sow the deceased alive on <i>5-17</i> 19 <i>64</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Veter V. Hodson MD</i>		DEGREE <i>MD</i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>5-26-69</i>							
22d. PHYSICIAN'S NAME (Type) <i>Jolley - Carmangy F.H. - Catonsville, Md.</i>		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>May 27 1969</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Cathedral Cem.</i>			23d. LOCATION (City or Town) <i>Baltimore</i>		(County) <i>Md.</i>		(State)			
24. FUNERAL DIRECTOR <i>Jolley - Carmangy F.H. - Catonsville, Md.</i>		ADDRESS			25a. REC'D BY REGISTRAR <i>MAY 28 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

2800

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

06983

06987

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or print) Margaret Jenkins Hamilton Wills	First	Middle	Lost	2a. DATE OF DEATH Month May	Day 29	Year 1969	2b. HOUR M
3. SEX Female	4. RACE White	S. DATE OF BIRTH 2-16-1886	6. AGE (In years last birthday) 83	7. IF UNDER 1 YEAR MONTHS 0			IF UNDER 24 HRS. HOURS 0
7a. BIRTHPLACE (State or foreign country) Charles Co., Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard			Md.
10. CITY OR TOWN OF DEATH Ellicott City	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 9526 Westwood Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) At Home		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 9526 Westwood Drive			
14. FATHER'S NAME John Edward Hamilton	First	Middle	Lost	15. MOTHER'S MAIDEN NAME May	Middle	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT John T. Wills - 9526 Westwood Drive Ellicott	Address City, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac vascular collapse DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years.							
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from 1957 , to 1969 , that (I) (we) last saw the deceased alive on 1964 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dorothy P. Wagner	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/29/69			
22d. PHYSICIAN'S NAME (Type) Lorraine Cemetery	22e. ADDRESS 33 York Street, Baltimore, Md.						
23a. BURIAL/CREMATION REMOVAL (Specify) Burial	23b. DATE 6-2-69	23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Cemetery	23d. LOCATION (City or Town) Baltimore, Maryland	(County) Charles	(State) Md.		
24. FUNERAL DIRECTOR Marion P. Arment	ADDRESS 4600 Lib. Hght Ave Baltimore 21207	25a. REC'D BY REGISTRAR JUN 2 1969	25b. REGISTRAR'S SIGNATURE Charles J. Wagner				

